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Case Report

Monkeypox mimicking chickenpox and sexually transmitted diseases: A case report and literature review

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ABSTRACT

Monkeypox (mpox) is a zoonotic viral infection caused by the monkeypox virus (MPXV) and may clinically mimic chickenpox and sexually transmitted diseases. We report a case of a 33-year-old male presenting with a five-day history of generalized vesicular eruptions involving the face, trunk, and inguinal region, accompanied by tender cervical and inguinal lymphadenopathy and low-grade fever. Initial differential diagnoses included chickenpox and sexually transmitted infections. Polymerase chain reaction testing confirmed mpox infection. The patient was treated with systemic valacyclovir, topical antiviral therapy, antibiotics for secondary bacterial infection, and strict home isolation. Significant clinical improvement was observed, with complete resolution of skin lesions and lymphadenopathy within ten days. This case highlights the diagnostic challenges of mpox in non-endemic regions and emphasizes the importance of including mpox in the differential diagnosis of vesicular eruptions. Further studies are required to clarify the role of valacyclovir in mpox management.

Key words: Infection, Monkeypox, Chicken Pox, Dermatology Outpatients, Valacyclovir

INTRODUCTION

Monkeypox (mpox) is an infectious zoonotic disease caused by the monkeypox virus (MPXV) [1]. MPXV belongs to the Orthopoxvirus genus in the Poxviridae family. It is an enveloped virus with a double-stranded DNA structure [2]. The condition might result in distressing cutaneous irritation, rash, swollen lymph nodes, and fever. Most individuals experience complete recovery, although a few may experience severe illness [2,3]. The symptoms of mpox closely resemble smallpox but are less severe, and mpox is seldom fatal. Individuals afflicted with mpox frequently develop a rash that can manifest on many parts of the body, such as the hands, feet, chest, face, mouth, or close to the genital region, including the penis, testicles, labia, vagina, and anus. The rash may first resemble papules or vesicles and cause discomfort or pruritus [3]. The rash progresses through 4 stages over 2-4 weeks: macules, papules, vesicles, and pustules [2]. Transmission of mpox from one person to another can occur through direct contact with infectious skin or other lesions, as well as during sexual activity [1-2]. The virus subsequently infiltrates the body by penetrating through damaged skin and mucous membranes, or it may spread by means of respiratory droplets. Transmission of mpox from animals to humans happens through direct contact with diseased animals. Individuals can also acquire mpox by contact with contaminated materials [2].

CASE REPORT

A 33-year-old male of Asian descent presented with a 5-day history of sudden vesicular eruptions that first appeared on the left side of the face and then involved the upper chest, abdomen, and right inguinal area associated with low-grade fever. The lesions on the face

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and trunk were itchy, while those on the genital region were painful. Systemic history revealed no significant visual, auditory, gastrointestinal, cardiovascular, or psychiatric problems. The patient reported no significant past medical history and no known allergies. The patient did not report contact with animals either. On examination, there were multiple molluscum-like umbilicated vesicles on the left side of the face and dorsal nose, multiple discrete vesicular exanthems on the chest and abdomen, erythematous tender swelling on the right side of the inguinal area associated with purulent discharge and crustation sign for secondary bacterial infection and abscess formation with enlarged lymph nodes on the cervical and right inguinal area, as shown in Figure 1 a - 1c. Physical examination revealed the following vitals and measurements (Table 1).

Pain assessment of vesicular rash on the skin revealed a moderate score on the numeric pain scale. The main site of pain was in the right inguinal area. Differential diagnoses included monkeypox, chickenpox, lymphogranuloma venereum (LGV), and human immunodeficiency virus (HIV). However, a suspected diagnosis of sexually transmitted disease was made, and a real-time polymerase chain reaction (PCR) was ordered. The swab was taken and sent for laboratory investigations to confirm the diagnosis. The results of PCR were negative for LGV and revealed a positive monkeypox infection. The patient was between stages 3 and 4 of Mpox infection.

Table 1: Vital Signs and Measurements

Name	Results
1. Temperature	36.3°C (Oral)
2. Heart Rate	78 (Peripheral)
3. Respiratory Rate	18
4. Blood Pressure	118/72 mmHg
5. SpO_2	100%
6. Height	172 cm
7. Weight	65 kg
8. Body Mass Index (BMI)	22 kg/m^2

The patient was immediately started on topical acyclovir cream, amoxicillin tablet 1gm BID for 10 days, 2% fusidic acid cream, and Valacyclovir tablets 500 mg TID for 10 days. Additionally, the patient was strictly advised to isolate himself. The assessment plan included following up on the patient for 10 days. After following the treatment for 10 days, the vesicular rashes on the skin started to heal and disappear completely, and even the enlarged lymph nodes resolved, as shown in Figure 2a - 2c.

LITERATURE REVIEW

Monkeypox disease is usually present in the regions of Africa, but recently, there has been an increased incidence and outbreak of monkeypox, even in non-endemic regions [4]. The literature suggests and supports a progressive rise in monkeypox case counts between 1980 and 2013 [5]. Therefore, we decided to conduct a literature review of the monkeypox cases that have been reported in the Gulf States. We searched "monkeypox" and "Gulf states" on databases such as PubMed and Google Scholar. The names of the countries were also added to the search string.

A bibliometric analysis conducted in 2022 [6] reported the monkeypox cases in Arab countries. It reported 16 cases in the United Arab Emirates (UAE) and 1 each in Qatar and Saudi Arabia [6]. Another study reported 8 cases in Saudi Arabia and 16 cases in the UAE [7].

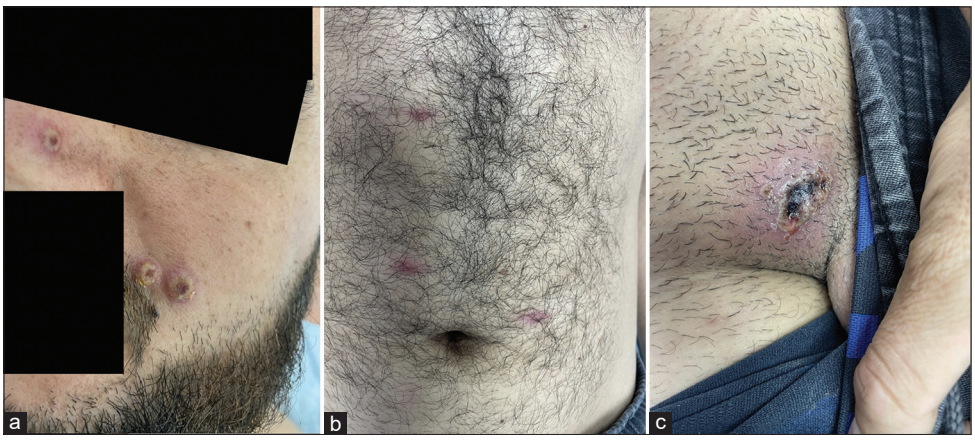

Figure. 1: (a) Shows large molluscum-like umbilicated vesicles on the left side of the face and dorsal nose. (b) Shows discrete vesicular eruptions in the upper chest and abdomen. (c) Shows right inguinal erythematous swelling associated with purulent discharge, crustations, and abscess formation.

Figure. 2: (a-c) Disappearance of vesicular lesions on the skin after following the treatment with Valacyclovir for 10 days.

Two cases of monkeypox individuals who travelled from the UAE to India were reported in the literature, each of which had developed fever and myalgia followed by multiple vesicular rashes all over the body [8]. Cervical lymphadenopathy and oral and genital lesions, which later progressed and formed on other parts as well, were the main characteristics [8]. One patient also developed umbilicated lesions and maculopapular rash. The use of acyclovir was prescribed [8].

A study revealed that the UAE had a considerable number of clinical assessments for monkeypox. However, the Middle East accounted for less than 0.1% of the total global monkeypox cases [9]. The clinical manifestations of the monkeypox cases in the UAE were comparable to those observed in Europe and America. Most of them exhibited genital lesions [10]. It is worth mentioning that the majority of monkeypox cases in the Middle East region had a recent travel history [9]. An observational study was conducted in Saudi Arabia [11], which reported the clinical features and the outcomes of the 7 travel-related monkeypox cases in Saudi Arabia. These cases either reported a history of heterosexual contact or other intimate encounters, which could be a cause of being infected. All the cases reported skin lesions, especially in the oral and penile regions. However, the cases were of mild severity and did not require antivirals, and the lesions disappeared in 15 days [11].

Various cross-sectional surveys were conducted in Saudi Arabia, where a rise in monkeypox cases was observed, and the knowledge and perceptions of people, medical students, and healthcare providers regarding monkeypox were assessed [12-15]. It was found that the public is more worried about COVID-19 than monkeypox [14]. Some studies revealed a satisfactory level of knowledge, while others found that a considerable proportion of the Saudi population lacks awareness regarding monkeypox and needs to be well-educated on this topic [12-15]. Another investigation evaluated the perception and anticipation of monkeypox among the general population in the Middle East and determined that there is a lack of awareness of monkeypox in the Middle East. Spreading information about monkeypox might be advantageous in managing the epidemic [16].

A systematic review and meta-analysis found that the UAE is one of the countries that reported the least number of cases of monkeypox [10], which is an indication of a research gap. The scarcity of publications indicates a significant disparity in scientific research output between Arab countries and advanced nations globally [6]. Therefore, Arab nations must promptly address the existing research gap in the field of monkeypox and should prioritize conducting original research to investigate various aspects of monkeypox, such as the recent surge in cases, the specific causes and origin of the disease, case tracing, preventive measures, treatments, and vaccines [6]. They should acquire the knowledge and skills necessary to manage cases of monkeypox promptly and efficiently.

DISCUSSION

Monkeypox was declared a public health emergency of international concern by the World Health Organization (WHO) in July 2022 [6]. It is a viral zoonotic disease whose incidence is increasing in different non-endemic countries [4]. The incubation period of monkeypox is 5–13 days, with a range of 4–21 days [1]. The infectious period spans from the onset of symptoms until the lesions have healed and the scabs have completely detached [2]. The most common systemic manifestations of monkeypox include fever, exanthema, inguinal lymphadenopathy, cervical

lymphadenopathy, asthenia, myalgia, and headache. After a few days of systemic symptoms, patients develop characteristic monkeypox lesions [10]. Our patient was also presented with fever, swollen lymph nodes, and vesicular lesions on the body parts. The findings of our case align with recently documented instances in which the simultaneous presence of genital lesions, rash, and systemic illness was frequently reported. It was also found that the patients who had more lesions had a longer duration of hospitalization [10]. However, in the case we reported, it was advised to isolate at home. It is necessary to isolate the patient because monkeypox can easily be transmitted from infected individuals to other individuals through contact [2,11]. The treatment of monkeypox is usually non-specific, but we gave valacyclovir to our patient, which bore fast results, and within a week to 10 days, the vesicular lesions began to disappear completely. While the primary treatments for mpox typically focus on supportive care, and the antivirals acyclovir and tecovirimat are more specifically approved for orthopoxvirus infections, valacyclovir has been considered in cases of co-infection with herpes simplex virus (HSV) or for individuals who might benefit from antiviral therapy for symptom management. Valacyclovir works by inhibiting viral DNA replication. Although there is limited clinical evidence supporting its use for mpox, our case had a rapid resolution of signs and symptoms. Therefore, in this case, treatment with Valacyclovir was associated with favourable clinical outcomes to enhance the rapid resolution of signs and symptoms and prevent shedding of the virus, thus minimizing further transmission. However, more research is needed to determine its efficacy and safety in treating monkeypox specifically, as most data currently available pertains to its use for herpesvirus infections rather than orthopoxviruses like monkeypox.

Monkeypox can progress and cause complications. Several complications have been reported in the literature, such as monkeypox-associated myocarditis [4], conjunctivitis, keratitis, and penile edema [10]. Highly likely to occur, but some other complications of monkeypox can be corneal lesions, encephalitis, and viral neuroinvasiveness [17].

However, recent literature found that physicians' understanding and attitudes toward monkeypox infection are insufficient and might be impacted by multiple circumstances. Nevertheless, it is necessary to raise clinicians' awareness regarding monkeypox because it is essential to promptly and thoroughly investigate and test for the monkeypox virus, even if other sexually transmitted infections have already been proven. Monkeypox virus-induced skin lesions are prone to bacterial superinfection, necessitating diligent monitoring of patients, even in cases of mild or moderate severity [18]. Monkeypox is also frequently confused with chicken pox, but there are some key differences between the two. The lesions caused by chickenpox tend to be mostly seen on the trunk and face, showing a "centripetal" pattern of distribution. On the other hand, monkeypox lesions are typically more extensive throughout the body, with lesions occurring in multiple locations concurrently [19]. Lymphadenopathy differentiates MPOX from chickenpox [20]. Monkeypox lesions may go through multiple stages simultaneously, such as macules, papules, vesicles, pustules, and crusts, whereas chickenpox lesions often progress at similar stages of development [19]. The contagiousness of chickenpox is higher than monkeypox. [21] The incidence of monkeypox has been lower in the past, particularly during the 1980s, as 85% protection was provided against monkeypox infection due to previous smallpox vaccination. Furthermore, the primary infection is less common as it requires zoonotic transmission [22].

There exists a significant gap in understanding between the treatment of monkeypox and its immunization [12]. However, the COVID-19 pandemic has yielded valuable insights that can potentially be utilized to address the 2022 Monkeypox outbreak, thereby mitigating its transmission and lessening its worldwide consequences [23]. Disseminating information about monkeypox to the public is crucial for enhancing their ability to reduce the impact of the disease and combat viral infections on a regional and global scale [13].

CONCLUSION

An unusual outbreak of monkeypox is re-emerging, and reports of the disease are circulating widely in non-endemic locations. Valacyclovir antiviral therapy was associated with clinical improvement in this reported case. We may be underestimating the severity of monkeypox based on the limited data we have, which could increase the number of cases around the world. Therefore, it is necessary to identify the research gap, that only a limited number of monkeypox cases are reported. Furthermore, it is necessary to raise awareness among medical professionals in nations where the disease is not prevalent. Clinicians should be educated

to consider monkeypox in the differential diagnoses when dealing with skin lesions, particularly when investigating HIV and sexually transmitted diseases. Simultaneously, it is also crucial to educate the public about monkeypox and its vaccination to raise awareness and fight against infectious diseases.

Statement of Ethics

Consent to publish statement: Written informed consent was obtained from participants for publication of the details of their medical case and any accompanying images.

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